How the NC Medicaid Program Works

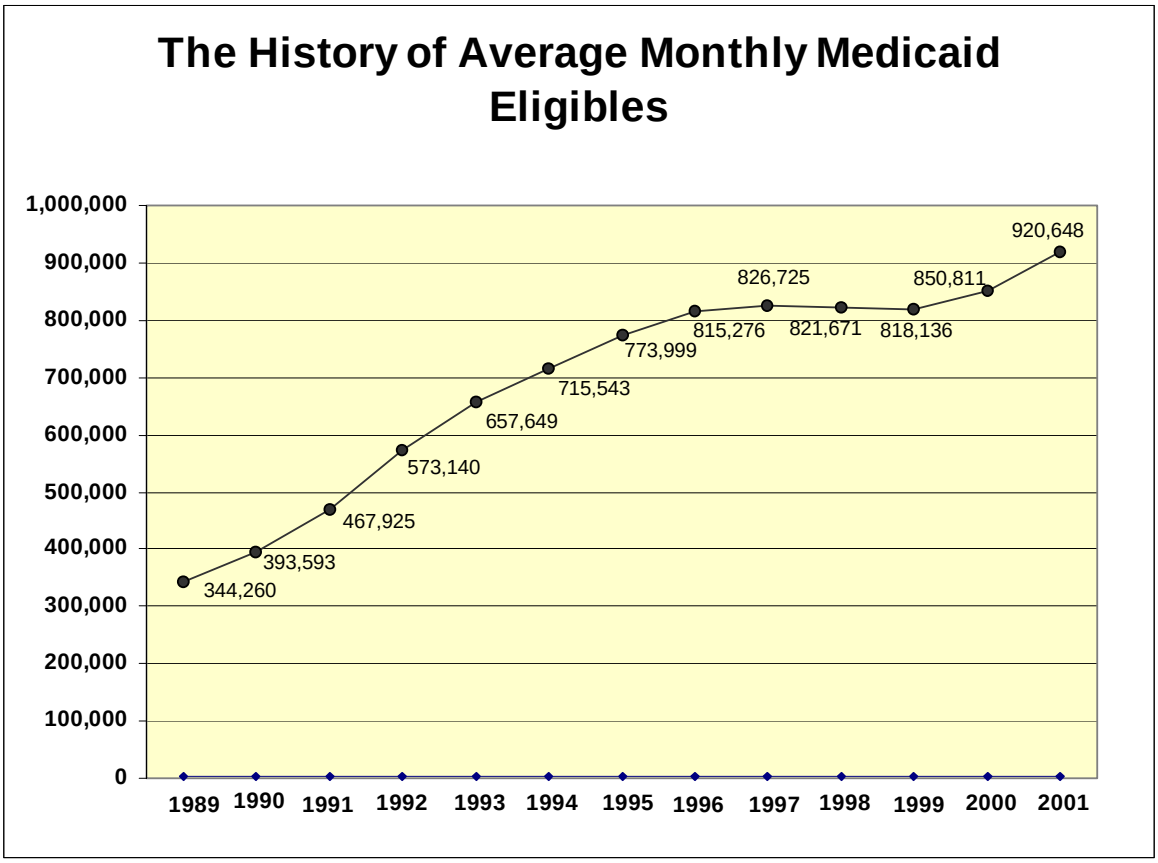
Major Sections:

nc department of health and human services

How the N.C. Medicaid Program Works

Brief History

North Carolina's Medicaid program began in 1970 under the direction of the North Carolina Division of Social Services. The Division of Medical Assistance (DMA) was created within the Department of Human Resources in 1978. From 1978 to 2001, the annual number of people eligible for Medicaid increased from 456,000 to 1,354,593 and Medicaid expenditures grew from approximately $307 million to $7 billion. As shown below, the number of average monthly eligibles has increased from 344,260 during SFY 1989 to 920,648 during SFY 2001.



In over 30 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of recipients. However, DMA has historically spent a modest percentage of its budget on administration. In SFY 2001, the DMA administrative budget was 1.3 percent of total service dollars and total administrative expenditures from DMA, other DHHS agencies, non-DHHS agencies and the counties was approximately 3.8 percent. The relatively modest level of administrative expenditures compared to other Medicaid programs in the nation became an important issue for the N.C. General Assembly as it began to put together the DMA budget for SFY 2002. The Legislature subsequently commissioned the services of a consulting firm to conduct a comprehensive study of DMA. They reported that "Limiting the size of the administrative staff can help control costs and reduce waste and

inefficiency. However, having a minimal number of staff can lead to overloads and bottlenecks, compromising staff members' ability to appropriately design, implement, and enforce Medicaid coverage policies."[1] Correcting this situation, while at the same time seeking other appropriate means of operational efficiencies and cost reductions, will continue to have a high level of significance well into the future.

"What is Medicaid?"

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and services within a state can change during the year.

Source: Centers for Medicare and Medicaid Services

For further general information about the Medicaid Program, eligibility and services, please refer to CMS's article "Overview of Medicaid" online at:
http://www.hcfa.gov/pubforms/actuary/ormedmed/default4.htm

Medicaid Eligibility

Medicaid provides funding for health care primarily to individuals who receive some form of financial assistance from the state. In North Carolina, caseworkers at each of the one hundred county departments of social services determine an individual's eligibility for Medicaid benefits based on policies established by the federal government as implemented by the State. Eligible families and individuals enrolled in the N.C. Medicaid Program are issued a Medicaid identification card each month. These individuals may receive medical care from providers who enroll in the Medicaid Program. Providers submit claims to DMA for reimbursement of services they render to the Medicaid population.

[1] "North Carolina Medicaid Benefits Study: Final Report", The Lewin Group, Inc., May 1, 2001

Basic Overview of Medicaid Eligibility

Who (coverage group)	Upper Income Limit	Assets *(see explanation below)*
Elderly Aged 65+	$716/month single person ($8,590 annually) $968/month couple (11,610 annually)	$2000 single person $3000 couple
Disabled/Blind	Same as elderly	Same as elderly
Medicare Beneficiaries	$967 monthly for single person ($11,597 annually) $1,307 monthly for couple ($15,674 annually)	$4000 $6000
Pregnant Women & Infants	$2,722 monthly for family of 4 ($32,653 annually)	n/a
Children ages 1 thru 5	$1,957 monthly for family of 4 ($23,475 annually)	n/a
Children ages 6 - 18	$1,471 monthly for family of 4 ($17,650 annually)	n/a
Persons aged 19 & 20	$362 per month for single person ($4,344 annually)	$3,000
Parents/Caretakers	$594 monthly for family of 4 ($7,128 annually)	$3,000
NC Health Choice (CHIP)	$2,942 monthly for family of 4 ($35,300 annually)	n/a
Medically Needy (must meet spenddown*)	$242 monthly for single person $317 monthly for couple	$2000 elderly & disabled person $3000 for couple or family

Notes:

- Home, 1 vehicle, personal property, burial money not counted as asset
- General requirements in addition to finances:
  - NC resident
  - Citizen or 'qualified alien'
  - Non incarcerated
  - Provide information on other health insurance
  - Provide Social Security Number
- *'Spenddown' is an amount of medical bills equal to the difference between income and the income limit; eligibility begins on day the 'incurred' medical bills equal the 'spenddown amount'
- Many 'spenddown' recipients are patients in nursing homes

Medicaid enrollees who have questions regarding their health care benefits may telephone the CARELINE, North Carolina's information and referral service, which is available toll free during regular business hours. If the CARELINE is unable to answer

the question, recipients are then referred to a DMA Recipient Ombudsman who works in DMA's Recipient and Provider Services Section. The Ombudsman ensures that the question is answered in a timely manner. During the period of January through June 2001, the Ombudsman answered questions for approximately 3,400 recipients.

Medicaid Eligibility by Mandatory and Optional Groupings	
MANDATORY	OPTIONAL
• Aged, Blind and Disabled receiving SSI • Children ages 1 - 5 up to 133% FPL • Foster children and adoptive children under Title IVE • Families with children <19 who would have been eligible for AFDC on July 1996 • Children ages 6 - 18 up to 100% FPL (mandatory as of 10/1/01) • Pregnant women and infants up to 133% FLP • Medicare beneficiaries up to 100% FLP qualify for Medicare cost-sharing • Medicare beneficiaries between 101 and 120% FLP qualify for payment of Part B premium	• Aged, Blind and Disabled not receiving SSI, including adult care home residents, 100% of poverty eligibles and medically needy • Non-IVE foster children and/or adoptive children with parents in families not eligible under AFDC rules in July 1996 (medically needy) • Children 19 and 20 • Pregnant women and infants up to 185% FLP

Funding the N.C. Medicaid Program

Federal, state, and local county governments jointly finance Medicaid, with the federal government paying the largest share of Medicaid costs. In North Carolina, the 100 county governments contribute 15 percent of the non-federal share of costs. The federal share of costs for services is established by the Centers for Medicare and Medicaid Services (CMS). CMS calculates the rate based on the most recent three-year average per capita income for each state and the national per capita income. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the State and counties to increase their share of Medicaid payments.

The established federal matching rates for services are applicable to the federal fiscal year (FFY), which extends from October 1 to September 30. The State's fiscal year (SFY) runs from July through June. Because the federal and state fiscal years do not coincide, different federal service matching rates may apply for each part of the overlapped state fiscal year. The federal match rate for administrative costs does not change from year to year.

Administrative Contracts

Certain functions of the Medicaid program are performed for DMA under contract. Some of these include:

EDS Corporation -- DMA contracts with EDS to perform many of Medicaid's administrative functions. Currently, EDS processes claims, serves as a focal point for provider questions and problems, trains new providers, operates the prior approval system for most Medicaid services, and operates the N.C. Medicaid Management Information System (MMIS Plus).

Medical Review of North Carolina (MRNC) -- MRNC conducts quality assurance reviews of the Community Alternatives Program for Disabled Adults (CAP/DA), Level of Care reviews for residents in Medicaid-certified nursing facilities, and the Health Maintenance Organization (HMO) contracts. MRNC also works with the DMA Program Integrity Section to evaluate provider DRG coding to identify improper reimbursement maximization and other potentially fraudulent billing practices.

First Health (FH) -- DMA contracts with FH to conduct pre-admission certification and concurrent reviews of inpatient psychiatric services for children under the age of 21 and adults. FH also conducts pre-admission and concurrent reviews for recipients in Psychiatric Residential Treatment Facilities (PRTFs). These reviews ensure that admissions and lengths of stay are medically necessary and appropriate for this population.

FH also conducts the federally mandated Pre-admission Screening and Annual Resident Review (PASARR) Program. This mandate ensures that all individuals – regardless of payment source – entering or residing in a Medicaid-certified nursing facility have been evaluated for serious mental illness (MI), mental retardation (MR), or a related condition (RC). It also ensures that these individuals are appropriately placed and treated. Individuals meeting the MI, MR or RC criteria are reviewed on an annual basis thereafter. Residents of Medicaid-certified nursing facilities exhibiting significant changes in mental health or mental retardation needs must be re-screened as a "change in status."

First Health Services Corporation (FHSC) – DMA contracts with FHSC to perform certain components of the retrospective Drug Use Review (DUR) Program. FHSC generates quarterly recipient and provider profiles from the paid claims computer tapes in accordance with the DUR Board's criteria.

Optical Contracts - Medicaid contracts with the N.C. Department of Correction's Correctional Enterprises to provide eyeglasses at predetermined rates. In most cases, providers of Medicaid eye care services must obtain eyeglasses through this organization.

Audit Contracts - The DMA Audit Section has contracts with two certified public accountants to conduct onsite compliance audits of nursing facilities (NF's) and intermediate care facilities for the mentally retarded (ICF-MR) who are enrolled in the Medicaid Program. These audits supplement DMA's in-house audit activities and verify the accuracy of the providers' cost reports.

In addition, DMA contracts with Blue Cross Blue Shield of Tennessee to perform Medicaid settlement activities for Rural Health Clinics and with Blue Cross Blue Shield

of North Carolina to perform Medicaid settlement activities for hospitals and State-operated NFs and ICF-MRs.

Partnerships

Although DMA administers Medicaid, other State and local agencies work closely in partnership with the program and perform important functions:

North Carolina Counties - The departments of social services in each of North Carolina's 100 counties have the central role in determining Medicaid eligibility for their residents. In addition, counties contribute approximately 5 percent of the cost of services for Medicaid patients (see Chart 2).

N.C. Division of Social Services (DSS) - The DSS conducts Medicaid recipient appeals when the person making the application contests eligibility denials.

Division of Vocational Rehabilitation Services (DVR) – DVR's Disability Determination Unit determines whether an individual is eligible for Medicaid based on disability. This unit also makes disability determinations for two federal programs under a contract with the Social Security Administration including Title II - Social Security benefits and Title XVI - Supplemental Security Income.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) - DMA works closely with the DMH/DD/SAS to plan for and monitor community mental health services. These agencies also work cooperatively to operate the Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD), a valuable resource for providing community-based services as a cost-effective alternative to institutional care in an ICF-MR. Under the federal mandate for PASARR, DMH/DD/SAS staff are authorized to make the final determination for service and placement needs for all those individuals identified with MI, MR or RC diagnoses.

Division of Public Health (DPH) - DMA and DPH cooperate in a number of efforts to improve care for people with HIV and AIDS. The AIDS Care Unit in DPH operates HIV Case Management Services (HIV/CMS) and the Community Alternatives Programs for Persons with AIDS (CAP/AIDS).

Women and Children's Health Section (WCH) – The WCH Section within DPH operates a variety of health care programs that are Medicaid-funded. WCH and local health departments also play a central role in the operation of the Baby Love Program, a care coordination program designed to assure appropriate medical care for pregnant women. It also plays a key role in the Health Check Program, which provides preventive and other health care services for children. Both programs are discussed in more detail in the "Programs" section of this report.

State Center for Health Statistics (SCHS) – The SCHS within DPH supports a variety of N.C. Medicaid's data needs for program planning and evaluation.

N.C. Office of Research, Demonstrations, and Rural Health Development - The N.C. Office of Research, Demonstrations, and Rural Health Development, an office within DHHS, provides technical assistance to small hospitals and community health centers in

rural and medically under-served communities. The Office also recruits health care providers to work in rural and medically under-served communities and provides grants for community health centers. The Office is the lead agency for demonstrations in the delivery and financing of health care for DHHS. Presently, they are working with DMA on the ACCESS II and ACCESS III managed care programs.

Division of Aging (DOA) - DMA and DOA staff work together on many issues that are important to the aged population. Jointly, DMA and DOA design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development projects on housing and in-home aide services.

Division of Facility Services (DFS) - DFS has the responsibility for licensing, certifying, and monitoring facilities in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

Department of Public Instruction (DPI) - The Individuals with Disabilities Education Act (IDEA) is the federal law requiring education-related services to be provided to pre-school and school aged children with physically and mentally challenging conditions. DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, such as speech, physical, audiological, and occupational therapies.

University of North Carolina at Chapel Hill (UNC-CH) - The UNC-CH School of Public Health and the Cecil G. Sheps Center for Health Services Research have collaborated with N.C. Medicaid on a number of research projects and efforts to support program planning and evaluation.

University of North Carolina at Charlotte (UNC-C) - Faculty within UNC-C have conducted evaluations of patient satisfaction with the Health Care Connection, N.C. Medicaid's mandatory HMO program in Mecklenburg County. They have also carried out and reported on a primary care provider availability survey for Carolina ACCESS.

Covered Services

N.C. Medicaid covers a comprehensive array of preventive and treatment services for eligible enrollees. Preventive services include one annual physical for adults and child health screenings provided under the Health Check (EPSDT) Program. Treatment services address virtually all acute and chronic illnesses.

Medicaid has certain standard limitations on services. These include a limit of 24 visits per SFY to practitioners, clinics, and outpatient departments and a limit of six prescriptions per month. There are exceptions to these limits for preventive care to pregnant women, children eligible for Health Check, people with life threatening conditions, participants in the Community Alternatives Programs (CAP), and other selected groups. Some services require nominal copayments and others require prior approval. Both requirements ensure that care received is medically necessary.

COVERED SERVICES	
MANDATORY	**OPTIONAL**
• Hospital Inpatient • Hospital Outpatient • Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21 • Other Laboratory and X-ray • Nursing Facility • Physician • Home Health • Health Check (EPSDT) • Family Planning • Durable Medical Equipment • Nurse Midwife and Nurse Practitioner • Hearing Aid • Medical Transportation • Federally Qualified Health Centers & Rural Health Centers	• Clinical • Diagnostic • Intermediate Care Facilities for the Mentally Retarded • Personal Care • Prescription Drugs • Dental and Dentures • Eye Care • Mental Health • Chiropractor • Podiatrist • Physical, Occupational and Speech Therapy • Hospice • Private Duty Nursing • Case Management • Nurse Anesthetist • Preventive • Rehabilitative • Screening • Transportation
Note: All optional services are mandatory for children under age 21	

Providers of Care

As of September 2, 2001, over 61,000 enrolled Medicaid providers offered a wide variety of services to North Carolina's Medicaid population. Many providers are enrolled in more than one type of service and participate with a group as well as individually. DMA's Provider Services Unit oversees the enrollment of new providers in the N.C. Medicaid Program and maintains licensing and credentialing information for providers enrolled with Medicaid.

Enrolled Medicaid Services Providers State Fiscal Year 2001	
Provider Type:	**Number**
Adult Care Home Providers	2,368
Ambulance Service Providers	381
Chiropractors	1,480
Community Alternatives Program Providers (CAP/C, CAP/AIDS, CAP/DD-MR, CAP/DA)	1,018
Dental Service Providers (Dentists, Oral Surgeons, Pediadontists, Orthodontists)	3,774
Durable Medical Equipment Suppliers	2,834
Hearing Aid Suppliers	183
Home Health Agency Providers (Home Infusion Therapy, Private Duty Nursing)	900
Hospice Agency Providers	74
Hospital Providers	381
Independent Laboratory Providers	167
Independent Practitioners (Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists)	3,227
Managed Care Programs (HMOs)	12
Mental Health Program Providers	154
Mental Health Providers	2,219
Nursing Facility Providers	1,296
Optical Service Providers and Suppliers (Opticians, Optometrists)	1,740
Other Types of Clinics (Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers)	209
Personal Care Service Providers	618
Pharmacists	2,251
Physician Extenders (Nurse Midwives, Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetists)	1,791
Physicians	32,212
Podiatrists	484
Portable X-ray Service Providers	24
Psychiatric Facility Providers	189
Public Health Program Providers	678
Rural Health Clinic/Federally Qualified Health Center Providers	357
Total	61,021

Rate Setting

Prospective payment rates and fee schedules are very important in controlling Medicaid program costs. Taking into account the level of funding provided by the N.C. General Assembly, payment rates are established according to federal and State laws and regulations. In-depth analysis of providers' cost of service is required to ensure fair and reasonable reimbursement. DMA reviews, monitors, and adjusts all reimbursement rates.

Program Integrity

DMA's Program Integrity Section is tasked with multiple responsibilities. These include:

- identifying fraud, abuse, and administrative overpayments in Medicaid billings by health care providers
- coordinating recipient fraud and abuse with the county departments of social services
- determining the accuracy of Medicaid eligibility determinations by the county departments of social services
- collecting money and cost avoiding Medicaid payments when a third party is responsible for paying for the Medicaid service
- ensuring, through prospective and retrospective reviews, that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and not likely to result in adverse medical effects.

The efforts of Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered.

Medicaid Eligibility Error Rate Reduction -- Program Integrity's Quality Assurance (QA) Section is responsible for monitoring the accuracy rate of eligibility determinations made by the county departments of social services in each of North Carolina's 100 counties. The QA staff conducts both federally mandated quality control reviews and State-designed targeted reviews. This review process looks at both active and denied cases. Error trends, error-prone cases, and other important error reduction information are communicated quickly to eligibility staff. DMA then works with the counties to promote corrective actions whenever appropriate. County eligibility supervisors then conduct evaluations and training and make the necessary adjustments to eliminate errors and to prevent future mistakes.

North Carolina has never been penalized for exceeding the 3percent federal tolerance level for payment error rates. North Carolina's low payment error rate is the result of a successful partnership between DMA and North Carolina's counties.

QA also coordinates with the counties on recipient fraud and abuse identification, prevention, detection, training, and recovery.

Investigation of provider fraud, abuse or administrative errors: Program Integrity staff use computer programs to identify unusual patterns of utilization of services. Medical desk reviews or visits are conducted for those providers or recipients whose medical practice or utilization of services appears outside comparative norms. Additionally, the staff investigates fraud complaints and allegations from many internal and external sources including calls made to the CARELINE to report fraud.

DMA Program Integrity efforts include:

- identifying providers and recipients who abuse or defraud the Medicaid program
- identifying and recovering provider and recipient overpayments
- educating providers or recipients when errors or abuse are detected
- protecting recipients' rights
- evaluating the medical claims processing procedures for accuracy and improvement

When an administrative overpayment is found, the staff recovers it from the provider. When possible fraud or abuse is suspected, the Attorney General's Medicaid Investigations Unit reviews it for criminal or civil prosecution

DMA operates several other programs directly or under contract to ensure that Medicaid funds are spent appropriately. These programs are designed to prevent and recover incorrect payments. DMA contracts with MRNC to evaluate DRG coding to identify improper reimbursement maximization and other potentially fraudulent billing practices. FH is under contract to conduct pre-admission, concurrent, and post-payment reviews of inpatient psychiatric admissions for children under the age of 21. In addition, paid claims are reviewed periodically and those that differ significantly from established norms are analyzed to determine whether the services were medically necessary and appropriate.

Third Party Recovery (TPR) -- Medicaid is, by law, the payer of last resort. As a condition of receiving Medicaid benefits, recipients agree to allow Medicaid to seek payment from available third party health care resources on their behalf. All other third party resources must be used before Medicaid dollars are spent. These resources, such as health and casualty insurance and Medicare, are important means of keeping Medicaid costs as low as possible.

Drug Use Review Program

N.C. Medicaid established a Drug Use Review (DUR) Program as required by OBRA of 1990 to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and are not likely to result in adverse medical effects. The DUR program is characterized by the following four major components:

- **DUR Board** - A DUR Board is composed of five licensed and actively practicing physicians, five licensed and actively practicing pharmacists, two other individuals with expertise in drug therapy problems, and the DMA DUR Coordinator. The DUR Board makes recommendations to DMA on DUR policies and procedures.
- **Prospective DUR** -- Prospective DUR requires that, prior to dispensing, the pharmacist must screen for potential drug therapy problems and counsel patients about the medications they are taking in order to enhance patient compliance.
- **Retrospective DUR** -- Retrospective DUR is an ongoing periodic examination of Medicaid claims data and other records to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients associated with specific drugs or groups of drugs and the appropriate treatment of disease states. These analyses are based on predetermined standards established by the DUR Board. North Carolina contracted with FHSC to provide the computer support for the retrospective DUR.
- **Education** -- Education is the key to an effective DUR Program. The DUR Program must provide ongoing outreach programs to educate physicians and pharmacists about common drug therapy problems with the goal of improved prescribing and dispensing practices.

The DUR Program uses a Provider Profiling System to complement the retrospective patient-based drug utilization reviews. This system is designed to be a retrospective characterization of drug use patterns. The Provider Profiling System identifies any prescribing and dispensing practices that deviate from accepted norms. These norms may be defined by the Board, taken from published literature or modified as needed. The Provider Profiling System is criteria driven and accommodates client-specific criteria within any of 12 broad problem types. Since the primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices, the providers who are profiled receive educational letters with profiles of each recipient who receives the medication and prescribing information related to the patient's drug therapy.

Utilization Management

Utilization Management functions ensure optimal health care delivery in a cost effective manner, to Medicaid-eligible individuals who either reside in a nursing facility or live at home. It is a joint effort by DMA and the fiscal agent to reimburse providers for services provided based on needs identified by completion of an FL2 or MR2 and authorized by a physician. The methods of these services are as follows:

Prior Approval

The prior approval function, carried out under a contract with EDS, encompasses medical services, long-term care, specific out-of-state hospital services, and other Medicaid services specified by DMA. Health care providers identify the need for services that require prior approval then complete and submit the State-specified prior approval request form and any applicable supporting documentation. Based on DMA's medical policy, approved medical criteria, and medical judgment, the EDS Prior Approval Unit is authorized to approve, pend or deny the request. Subsequently, the MMIS prior approval files are updated with the information from the request, indicating that the request has been approved, pended for additional information or denied. The claims processing system accesses the prior approval file to validate that the provider's services are consistent with the authorization prior to adjudicating the claim for payment. EDS uses policies developed by DMA to maintain a current Medicaid policy library. In all matters of policy, regulations, and compliance, the EDS Medical Director collaborates closely with DMA.

CAP Utilization Review

CAP/DA cases, randomly selected on a monthly basis from among all lead agencies for CAP, are monitored by MRNC. Quality assurance (QA) reviews determine that clients are classified correctly at either intermediate care or skilled nursing level of nursing facility care. The review also determines that clients have been given the option to choose home care versus nursing home placement, that the plan of care is relevant to the assessed needs of the clients, and that the health, safety, and well-being of clients is reasonably assured by the services provided. Results of the monthly monitorings are reviewed by DMA CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/DA is operated. The QA review process is not a negative process, but one that leads to the

strengthening of programs, enabling agencies to better serve individuals who have nursing facility needs but opt for the range of home care services available through CAP/DA.

Behavioral Health Prior Approval

Prior approval is required for all psychiatric/substance abuse inpatient hospital care, all psychiatric residential treatment facility (PRTF) care for recipients under the age of 21, all residential treatment levels of care II through –IV, after 8 outpatient therapy visits for adults and after 26 outpatient visits for recipients under the age of 21. Medicaid has a contract with ValueOptions to perform utilization review.

Managed Care Prior Approval and Utilization Management

Each recipient that is enrolled in either Carolina ACCESS, ACCESS II or ACCESS III chooses or is assigned to a primary care provider (PCP). The PCP serves as "gatekeeper" for the recipient in achieving the dual goals of improving access to care while reducing unnecessary costs. The PCP is expected to provide 24 hour, 7 day per week access to medical care for enrolled members and to arrange for after hours coverage and authorization (prior approval) for appropriate referrals for specialty care as needed. The PCP provides the referral physician with an authorization number that must appear on the medical claim to ensure Medicaid reimbursement.

From the perspective of the Managed Care Section, utilization management is a process that is used to ensure that appropriate services are delivered to Medicaid enrollees through the identification of aberrant utilization patterns and potential quality of care issues. The process provides the opportunity to identify areas to target for the development of quality improvement activities. Utilization Management also serves to provide the Managed Care Section with cost data based on service utilization, which affords cross-analysis of the efficiency and effectiveness of managed care program types.

Each Carolina ACCESS, ACCESS II, and ACCESS III provider receives quarterly utilization reports and monthly Emergency Department and referral reports. Data contained in these reports is abstracted by EDS from paid claims data. These utilization reports include both inpatient and outpatient utilization statistics and are useful for peer performance comparisons. The Managed Care Quality Management Unit produces internal reports that stratify the data according to provider specialty and the number of enrollees per provider.

Participating managed care organizations (MCOs) are required by contract to have a written utilization management program that is consistent with federal regulations and includes mechanisms to detect under/over-utilization of services. The written description must address procedures to evaluate medical necessity, the criteria used, information sources, and the process used to review and approve the provision of medical services. MCOs are also required to submit encounter data to EDS within 90 days from the end of the month in which the service was rendered. DMA and EDS continue to work with the

MCOs to develop an encounter reporting process that provides data that accurately reflects the delivery of services to enrollees. Additionally, the MCOs are required to submit HEDIS data, emergency department visits, inpatient utilization, ambulatory surgical procedures, OB discharges, and newborn data derived from their internal data collection systems to DMA on an annual basis.

Nursing Facility Prior Approval and Retrospective Review

In order for Medicaid to pay for placement in a nursing facility, an individual must meet both financial and medical eligibility requirements. The county departments of social services have the responsibility of determining financial eligibility. DMA contracts with their fiscal agent, EDS, to determine medical eligibility by utilizing a prior approval process. Prior approval does not guarantee financial eligibility or Medicaid payment.

In addition to the prior approval process for level of care, North Carolina is mandated to perform pre-admission screening – part of the PASARR process – for all residents applying for, or residing in, a Medicaid-certified nursing facility. This statutory requirement became effective January 1989 as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203). This section of OBRA was enacted to assure that recipients with serious MIMR, or RC conditions entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services. The pre-admission screen (Level I and, if appropriate, Level II) must be completed and the special identification number, known as the **PASARR** number, must be documented on the State-approved FL2 prior approval form before nursing facility level of care will be considered.

North Carolina has two distinct levels of care for nursing facility placement (skilled and intermediate) that are governed by the Level of Care Criteria. The **FL2** form is used to document information specific to the individual including diagnoses, special care needs, requested level of care, and the PASARR number. This information is used to determine the appropriate level of care. The **FL2** must be completed with current information and must be signed and dated by the physician. Prior approval requests are generally initiated via telephone and must be submitted to EDS within ten working days of the telephone review. Requests can also be initiated by written review. Records may be attached to justify the requested level of care.

On January 1, 2001, DMA initiated a change in procedure for consideration of retroactive prior approval requests. If the retroactive request is within 30 days from the telephone prior approval or FL2 criteria review, medical records may not be needed by EDS to make a level of care decision. If the retroactive request is for a time period exceeding 30 days, medical record documentation will be required by EDS to support the retroactive request and level of care decision. Retroactive prior approval will not be granted for time periods exceeding 90 days from the date Medicaid eligibility was determined. In addition, requests exceeding 90 days when unusual circumstances occur must be submitted to DMA for consideration of approval. Certain requests where it can be proven that the provider failed to determine eligibility or follow the prior approval level

of care process will be denied. Under these circumstances the resident or family cannot be billed for services provided.

ON-LINE ADDENDUM A TO NC MEDICAID SFY 2001 ANNUAL REPORT

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